NETWORK A national newsletter on substance misuse management in primary care

network

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Rationale for the use of methadone

Excerpt from *Guidance for the use of methadone for the treatment of opioid dependence in primary care.* RCGP Substance Misuse Unit, RCGP Sex, Drugs and HIV Task Group, SMMGP, The Alliance, 1st Edition 2005 available at www.smmgp.org.uk

> **Methadone is an effective substitute medication for opioid dependence for use in UK primary care.**

There is an increasing body of evidence that the primary care setting is an effective means of delivering treatment for opioid dependence.[10,11,12,13] Methadone maintenance treatment (MMT) is now a well-established treatment modality across a variety of treatment settings and supported by both research evidence and clinical practice.[14,15,16,17,18,19.]

The aim of methadone maintenance treatment is to improve the quality of life of opioid-dependent patients and to reduce the potential harm of using illicit drugs. MMT greatly reduces mortality,[20] illicit drug use and criminal activity, and attracts and retains more patients in treatment than other treatments.[9] There is good evidence that MMT reduces transmission of HIV,[21,22,23] although the evidence for effectiveness at reducing transmission of hepatitis B virus and hepatitis C virus is less convincing.[24,25,26]

There is no evidence that MMT increases the overall length of dependence.[14] The positive outcomes of MMT are only sustained while patients are in treatment. Effective treatment of the parent can also have major benefits for the children of problem drug users.[27]

Methadone is a highly effective maintenance treatment for chronic dependent opioid users that can deliver a wide range of harm reduction outcomes for large numbers of patients in a wide variety of settings. However, effectiveness may be reduced by departure from optimum methods of delivery. Enforced reductions in the methadone dose and putting pressure on patients to become abstinent from methadone are associated with poor outcomes.[28]

The most effective MMT programmes are those that provide optimal doses (usually between 60 to 120mg daily) of methadone as part of a comprehensive treatment programme, which will include regular reviews, general medical care and psychosocial support as required, and which validates maintenance as much as abstinence as desirable treatment goals [9, 17, 29] and where patients feel they play a meaningful role in determining their optimum dose.

A summary of the evidence in 1999 concluded that given the high morbidity and mortality seen in patients with opioid dependence not in treatment, the public health challenge was to deliver safe and effective methadone treatments to as many patients as could benefit from it, while minimising the risk of diversion of prescribed medication.[14] Whilst methadone clearly remains the mainstay of the public health response, there has been an increase recently in the use of buprenorphine for some patients. Also with more patients now in treatment, increasing access to psychosocial and other supportive interventions in addition to the pharmacotherapy is important.

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Welcome

It is an exciting time for the updated smmgp.org.uk website as we celebrated our 100,000th hit in January. With more than a quadrupling of weekly hits over this past year, the site is now receiving as many as 2,500 regular home page hits a week not counting the discussion forums or other routes into the site. So take a look, try out the forums or download a conference brochure as we look forward to seeing you shortly in Manchester for yet another stimulating RCGP SMMGP conference on 27th and 28th April – *Are we Delivering Effective Care in General Practice?* (www.smmgp.org.uk.)

IN THIS ISSUE - We showcase the RCGP SMMGP ***Methadone Guidance*** **on *pages 1-3*** with excerpts of the *guidance summary, the rationale for methadone prescribing and advice on when to choose between maintenance and detoxification.* These excerpts also highlight some of the key treatment principles which primary care has been keen to promote (See the full guidance on www.smmgp.org.uk).

In case you have ever felt lost interpreting your patients' ***jargon and the weights and measures of the illicit drugs scene (page 4),*** Dr Gordon Morse provides some witty and insightful tips courtesy of an ambiguous but seemingly authoritative source.

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Page 5 offers a ***synopsis of the drug problem across Europe following EU Drugs Agency*** reporting – definitely worth a glance to see how our local patterns fit with the EU trends. Critically, polydrug use is now considered central to the EU drug phenomenon making a simple substance specific focus no longer appropriate.

With the EU trend towards treatment rather than prisons, Tom Carnwath's excellent outline of ***current and future treatment issues in prisons on page 6*** is most relevant and useful.

SMMGP continues to look towards supporting the key strategic role of shared care coordination for effective development and maintenance of local treatment systems. Kate Halliday has drawn together SMMGP team experience into a ***Briefing Paper on Shared Care Monitoring Groups, pages 8 - 9.***

Where the GP's responsibility lies in terms of ***patients on methadone who drive (page 9)*** continues to concern many…look no further than the Methadone Guidance.

A much-needed DH update on legislation and developments in the ***management of controlled drugs post Shipman*** is presented ***on page 10.***

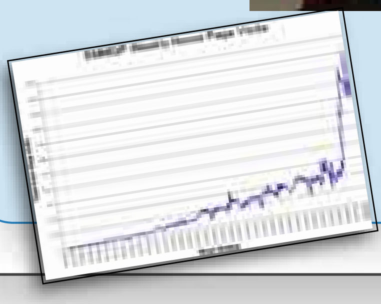
Fittingly its a multidisciplinary team that tackles the importance of ***integrated care and partnership working on page 11*** with some practical highlighting of joint working between the criminal justice, local specialist and GP services.

Dr Fixit on pages 12 - 13 has been doing what he does best, offering practical advice – firstly on ***joint working around substitute prescribing and crack alcohol and social legal problems*** and secondly on how best to support a patient ***coming off supervised consumption.*** Thanks Dr Stephen Pick and Dr Judith Yates for their Fixit experience and insights.

'Page 14 looks at how the ***Respect, antisocial behaviour agenda*** is affecting vulnerable drug and alcohol patients, with ***updates, news, courses*** and the like ***on pages 15- 16.***

Enjoy the issue and hopefully see you at the Manchester conference in April.

Jean-Claude Barjolin, Editor



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Guidance for the use of methadone summary

Excerpt from Guidance for the use of methadone for the treatment of opioid dependence in primary care. RCGP Substance Misuse Unit, RCGP Sex, Drugs and HIV Task Group, SMMGP, The Alliance, 1st Edition 2005 available at www.smmgp.org.uk

Opioid dependence is common in the UK and methadone is an effective treatment.

Effective:

- Methadone is an effective evidence based medication used for the treatment of opioid dependence.
- It is most effective when used as a maintenance agent at optimal dosing.
- Its primary function is to reduce (and eventually replace)illicit opioid use and in so doing, reduce harm and improve the health and psychological well-being of the patient.

Maintenance and detoxification:

- Choosing between maintenance and detoxification occurs at many points during treatment, starting at the first assessment and then at various points as appropriate.
- Methadone can be used as a maintenance intervention or sometimes as a detoxification agent.
- Other medications, such as buprenorphine and lofexidine, may be more effective for detoxification in some patients.

Methadone maintenance:

- Methadone is still considered the gold standard for long-term opioid dependence.
- Optimal dose for maintenance is usually between 60 to 120 mg daily (some people need more and some less).
- Methadone is usually prescribed in an oral formulation: methadone oral solution (mixture) 1 mg/ml.

Assessment:

- Before prescribing methadone, opioid dependence must first be confirmed by history and examination, including physical examination, and by toxicology screening using urine or oral fluid swabs.

Titration:

- Due to the risk of overdose, the starting dose should be between 10 and 30 mg daily.
- For patients on other sedative drugs, including benzodiazepines or alcohol, the starting dose should not be more than 20 mg daily.
- Doses should then be titrated upwards to optimal levels, usually between 60 and 120 mg.
- Increases of between 5 to 10 mg a day with a maximum of 30 mg a week for the first two weeks (after that it can be slightly quicker).
- The consumption of methadone doses should be supervised for at least the first three months and until the patient has gained stability, unless there are important other considerations (e.g. employment, child care responsibilities) and the risk of diversion has been assessed as low.
- Methadone should initially be prescribed in daily installments, on FP10 (MDA) in England and Wales or GP10 (3) in Scotland.
- It is the responsibility of the prescriber to ensure safe induction on to methadone. This responsibility cannot be delegated. However, a close working relationship with pharmacists and drug workers can be helpful in facilitating titration to an adequate dose as quickly as possible.

Stabilisation:

- Stabilisation involves finding a suitable dose that keeps the patient engaged in treatment without the need to supplement with other drugs and/or heroin.
- The process of psychosocial stabilisation usually begins once drug use has begun to stabilise.

Interactions:

- Methadone interacts with other central nervous system depressants including benzodiazepines, antidepressants and alcohol, increasing the risk of overdose and patients must be informed of this.
- It can be particularly dangerous to use any sedative drugs, including heroin and benzodiazepines, especially by injection, while taking methadone.
- Drugs that increase metabolism such as rifampicin or phenytoin, may mean higher doses of methadone are needed to compensate.

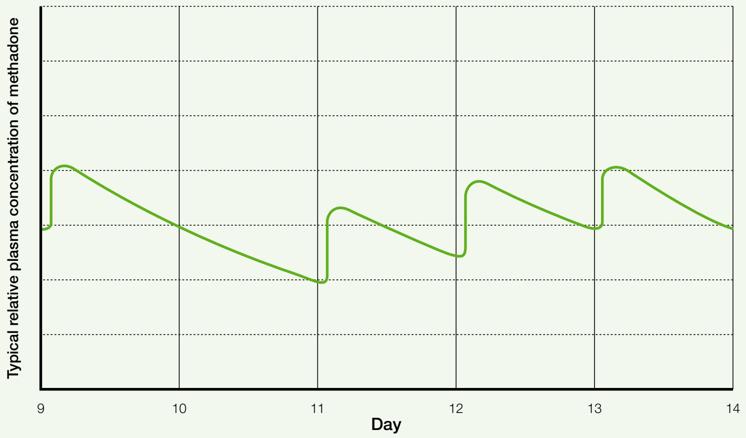
Loss of tolerance:

- It is important to remember that several missed doses may mean a loss of tolerance.
- Three days missed consecutively should lead to a dose review and possible reduction in dose.
- Five days or more missed consecutively should lead to re-assessment and re-titration.
- The tolerance to opioids maintained by people on adequate methadone treatment is an important protective factor against overdose: people on adequate treatment are far less likely to overdose than opioid users not in treatment.

Ongoing care:

- Treatment is reviewed at every contact and needs to be reviewed formally, at least every three to four months, to measure improvements in health and well-being.
- A toxicology screen (urine or oral fluid swab) needs to be taken frequently in the beginning of treatment and, when stabilised, between two and four times a year to confirm use of medication and monitor treatment.
- Toxicology screens should never be used punitively, but as an aid to treatment.
- Screens positive for heroin, or other drugs, require a review of treatment and dose and should not normally lead to the cessation of treatment or dose reduction.
- It is important that patients are given good information on methadone's actions and effects and advice on safe storage of take-home doses.

Three day recovery to steady state from missed dose at day ten



After a missed dose it can take three days for blood levels to return to normal.[42]

Shared care:

- Treatment of drug users is multifaceted and normally requires a multidisciplinary response and, wherever possible, should be provided in collaboration with others such as other primary care workers, practice nurses, dispensing pharmacists, practitioners with a special interest and addiction specialists.
- Practitioners should only treat and prescribe to the level of practice at which they feel competent and confident.
- More stable patients may not need so much additional input.
- Shared care should be encouraged to meet the needs of the individual, not a specific drug.

Illustrations adapted from 'The Methadone Briefing' (1996) – www.exchangesupplies.org

Choosing between maintenance and detoxification

Choosing between maintenance and detoxification occurs at many points during treatment, starting at the first assessment and then at various points as appropriate. Methadone can be used as a maintenance intervention or as a detoxification agent, but is primarily now used as a maintenance drug. Methadone is probably no longer seen as the automatic first-line treatment for all patients wishing to detoxify from heroin. Many find that buprenorphine and lofexidine enable easier assisted withdrawal, although the evidence is not overwhelming.[35] It is important to consider the views of the patient if they express a particular preference for any of these medications.

Maintenance is suitable for patients who want to stop using illicit opioids but are unable to achieve abstinence from all opioids at present. Prescribing is offered long-term, at effective doses (usually between 60 to 120 mg daily) individualised for each patient. The goal is harm reduction and stabilisation of life-style. It may also be prescribed on harm reduction grounds to those wanting to reduce their consumption of illicit opioids. The most powerful evidence base for methadone is for long-term maintenance, with retention in treatment being an indicator for better outcomes.[9, 14]. Enforced detoxification or enforced dosage reduction has been shown to be ineffective.[28, 40]

Detoxification can be attempted with highly motivated, willing patients who wish to detoxify from all opioids. However, the likelihood of success with methadone will be reduced if the process is too rapid because of the long-acting nature of the drug and its prolonged withdrawal profile. It is important to assess whether the patient's circumstances are conducive to maintaining abstinence and to advise on the timing of withdrawal accordingly. Where circumstances are adverse, such as patients who are homeless or awaiting court, a further period of maintenance should be advised with support to achieve appropriate stability and psychosocial change before attempting detoxification.

There is a high relapse rate to heroin use and as such detoxification should always be seen as a stage in the process and not normally be seen as a stand-alone treatment modality. It should never be imposed, particularly since recent research has shown high mortality rates among those detoxified.[41] Detoxification should be followed by a package of care, which can include: in and outpatient rehabilitation, relapse prevention, support, self-help groups and counselling. It is crucial to warn of the potential loss of tolerance to opioids after a detoxification – relapsing to heroin after a period of abstinence may be fatal. If patients are moving from maintenance to detoxification they may need to reduce their dose of methadone before transferring to another drug such as buprenorphine. Lofexidine is still sometimes used but the evidence for its effectiveness is poor, especially used as a single agent. If in doubt seek specialist advice.

Excerpt from Guidance for the use of methadone for the treatment of opioid dependence in primary care. RCGP Substance Misuse Unit, RCGP Sex, Drugs and HIV Task Group, SMMGP, The Alliance, 1st Edition 2005 available at www.smmgp.org.uk

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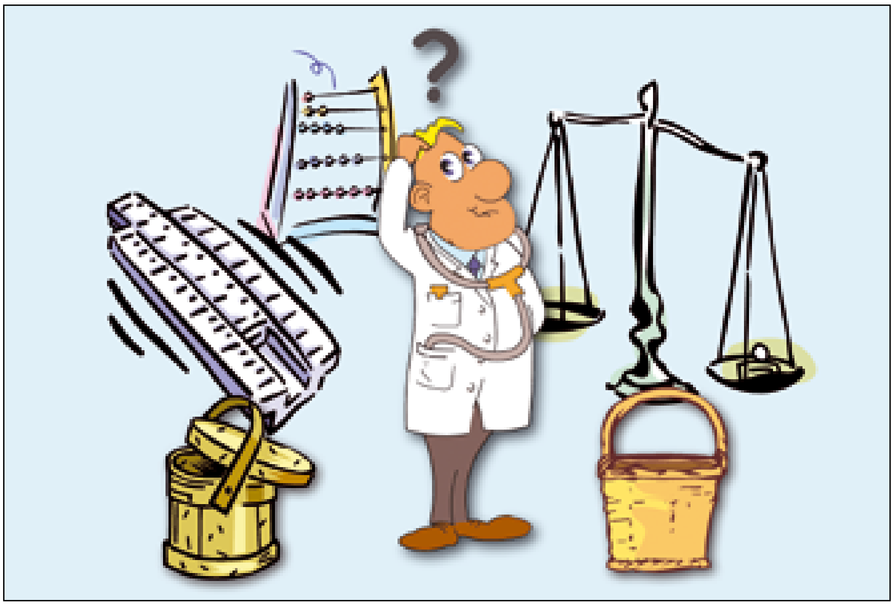


Dealing with weights and measures

In case you have ever felt lost interpreting your patients' jargon and the weights and measures of the illicit drugs scene, Dr Gordon Morse provides some witty and insightful tips courtesy of an ambiguous but seemingly authoritative source.

Drug users confuse us with many things, but I particularly struggle with their weights and measures, because they insist on using both metric and imperial measures, and dress it all up in confusing jargon as well.

So I asked one of my punters to give me a tutorial, an I pass this on to you. But note, these things change quickly, so I cannot guarantee how long these prices and information will remain true for. I can however testify to the authority of the source!

When dealing in heroin, cocaine and crack cocaine, the following measures apply:

A typical £10 deal, bag, wrap etc will contain 0.15-0.4g of drug (note the wide range of purity). (Also note that you cannot equate ANY amount of heroin with an "equivalent" dose of methadone for reasons of purity and the variability of individual physiology*)

28g = 1 oz

7g = ¼ oz

3.5g=⅛ oz

A "teenth" (ie. 1⁄16 oz) should contain 1.75g, but is usually more like 1.5g

A "Nine Bar" is 9oz (250g), and there are 4 Nine Bars to 1 kilogram (36oz)

Cracking cocaine

A dealer will begin with a large amount of powder cocaine, say 1 kilo, or a Nine Bar. Nine Bars of good powder cocaine cost £8000 wholesale. This can then be "re-pressed" (cut or diluted) with a pharmaceutical inert powder called Mannitol, costing £50 for 1kg.

1oz of good powder cocaine might cost £1100, but re-pressed powder cocaine might be £800. Most cocaine sold in ounces or less will have been re-pressed.

"Washing up" powder cocaine into crack, using ammonia or bicarbonate etc, will generally lose some weight of cocaine. But 1oz of powder (cost £800) can be turned into £1400 of rocks if sold in £10 amounts.

Grass is greener

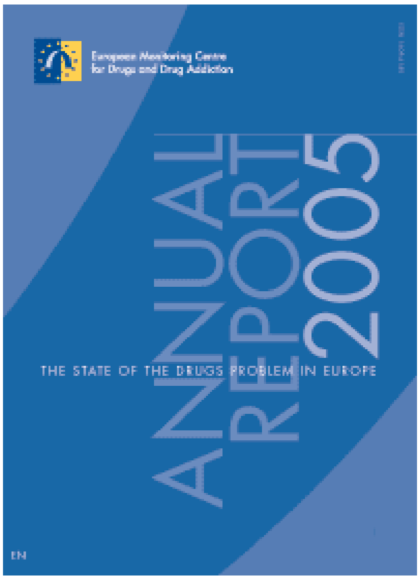
The best value in dealing comes from buying grass in kilos – apparently a punter can double their money.

Dr Gordon Morse

*As stated in the Clinical Guidelines, Department of Health; the Scottish Office Department of Health and Social Services, Northern Ireland. Drug Misuse and Dependence – Guidelines on Clinical Management. London: HMSO, 1999

Latest on the drug problem across Europe

The 2005 annual report from the EU drugs agency offers a very useful overview of the European drug phenomenon in 29 countries across Europe - giving latest trends, analysis, social, legal and political responses. So here is a synopsis – certainly worth a quick glance to see how our local patterns fit with those in Europe.



PDF files of printed version are available at http://ar2005.emcdda.eu.int

Polydrug use is central to EU drug phenomenon making a simple substance specific analysis no longer realistic.

- Analysis must take into account the complex picture of the inter-related consumption of psychoactive substances, including alcohol and tobacco.
- Upward trend in amphetamine and ecstasy use in most EU countries mainly by young adults.
- Cannabis is still Europe's most popular drug. Over 62 million Europeans have tried cannabis (or over 20% of all adults). Roughly 3 million young adults, mostly males, are estimated to be daily or almost daily users.

Cocaine is becoming the stimulant drug of choice for many young Europeans and a major element of the EU drug picture

- Around 9 million Europeans have tried cocaine in their lifetime (3% of all adults).
- Between 1% and 11.6% of young adults have tried cocaine. Use is mainly among young, urban males.
- Around 10% of requests for treatment for drug problems in the EU are linked to cocaine use.
- Cocaine has a 'determining role' in around 10% of drug deaths; but deaths by cocaine use alone are rare.
- New concerns exist around the links to cardiovascular problems
- Crack cocaine is mainly limited to a few big cities (NL, UK).

Opiate use

- Numbers of new heroin users may have fallen across Europe with a peak in most countries in the early 1990s, with evidence of decline in injecting. In Denmark, Greece, Spain, France, Italy and the UK, less than 50% of new opiate users entering drug treatment say they inject.
- Over half a million Europeans now receive substitution treatment. Use of buprenorphine is now more common. There have been major increases in services for opiate dependence, seven-fold over last decade, whereas treatment for other drug problems is more limited.

Blood borne viruses and mortality

- Heterosexual transmission has overtaken injecting drug use as a route of new AIDS cases. Overall there is a low HIV prevalence among IDUs.
- Hepatitis B and C are still major causes of disease among IDUs.
- Overdose is the main cause of death among opiate users, but numbers of young fatalities are falling.

Rise in drug law offences in most of the EU

- Upward trend in 20 countries (1998–2003) with drug use or possession for personal use accounting for largest proportion of drug law offences.
- Proportion of drug law offences involving cocaine generally increased (98–2003).
- Cannabis is still the drug most often cited in drug law offences in most of the EU.
- Heroin-related offences fell in all reporting countries (1998–2003), except Austria and the UK.

Countries opt for treatment over prison

- For many problem drug users, prison can be a particularly detrimental environment.
- Broad political consensus exists to divert drug using offenders from imprisonment to treatment.
- Prisons are overcrowded – treatment option can be a more cost-efficient way of sentencing.
- The new EU drugs action plan 2005–2008 asks Member States to 'make effective use of, and develop further alternatives to, prison for drug abusers who commit drug-related offences'.

Policy-makers support data collection

- Strong consensus on need to base actions on a sound understanding of the drug situation and to share experience on what works to respond to it.

Addiction treatment in prison

The European trend is towards treatment rather than prisons, making Tom Carnwath's excellent outline off *current and future treatment issues in prisons* most relevant and useful.

Tom Carnwath, Consultant Psychiatrist, Substance Misuse, Darlington

Proper management of drug-using prisoners is vital, partly because often they have no other contact with treatment. Studies have consistently demonstrated very high drug use by prisoners. About half have used cocaine or heroin recently, the prevalence for each drug being about 30%, compared with less than 1% in the general population. In prison about 50% of prisoners use cannabis, 25% heroin and 15% illicit tranquillisers. Other drugs are less common. Frequency of use is usually less than outside prison. About 15% of cannabis users and 3% of heroin users use daily, but only about 2% admit injecting in prison. About 25% of prisoners who have ever used heroin use it for the first time while in prison. During the first few months after release, drug use is slightly less prevalent than before imprisonment [1,2]

Drug withdrawal on admission is associated with self-harm. 11% of suicides occur during the first 24 hours in prison, 33% in the first week and 47% in the first month. 62% of these are problematic drug users [3]. The risk of death during the first week after release is forty times higher than expected in this population, usually as a result of opiate overdose[4].

Methadone has traditionally been used in our prisons merely as a means of detoxification. Regimes have typically started at 30mg/day, reducing to zero over ten days [5], although recent recommendations propose that this should be extended to three weeks or perhaps much longer. There is scant evidence to guide this decision. Lofexidine, buprenorphine and dihydrocodeine have been used as alternatives, although the latter is now discouraged because it is not licensed for this purpose.

There is growing interest in the use of methadone maintenance treatment in prison. An Australian randomised study showed that heroin-using prisoners treated with methadone throughout their imprisonment were less likely to die after release or to come back into prison [6]. The same team also showed a reduced rate of overdose, injecting and hepatitis sero-conversion during imprisonment, but only if methadone doses were above 60mg/day [7]. Only a few UK prisons provide maintenance treatment at present, but this will change in the near future.

The principles of induction on to methadone are the same as those used in the community. Many patients coming into prison are already on methadone prescriptions. Much caution is required, because often there is a lapse of days between their last community dose and initiation of prison treatment, as a result of temporary detention in police cells, weekend admission etc. Tolerance to opiates is lost at the rate of about 20% per day. Moreover, unless the last community dose was supervised, it is not absolutely certain that the full dose was actually taken. Prescribing the same dose as was used in the community can therefore cause fatal overdose. In most cases it is safest to start dose levels at 40mg/day or less, but possibly increasing them faster than in newly-induced patients, depending on response. Split dosing is helpful during titration. Methadone consumption in prison is always carefully supervised, and followed by a wash-down drink of water, to prevent the onward sale of “spit methadone”.

Some prison guidelines argue that patients require lower doses of methadone in prison than in the community, partly because there is less access to illicit drugs, but the logic of this argument is unclear (e.g. Victoria Prisons [8]). The evidence quoted above suggests that effective therapy requires the same dose range in both prison and the community, namely above 60mg/day for most patients.

Buprenorphine brings less risk of overdose. Doses can be increased if required by 4mg/day as in the community. It may however cause other problems in a prison setting. It is the most common drug of abuse in many prisons. Doses are difficult to supervise, and mouthed tablets can later be injected with consequent risk of abscesses and viral infection. It is often used in detox programmes, usually over ten days.

Prison offers an excellent opportunity to provide psychological treatment and health promotion, focussing on such issues as diet, safe injecting and smoking, prevention of overdose and first aid. Many prisoners are heavy cocaine and alcohol users before imprisonment, but few use cocaine while in prison and none use alcohol. Nonetheless, treatment related to these drugs can still be effective. Indeed, the mental effect of heavy cocaine and alcohol use can sometimes render treatment very difficult while outside prison or other residential facility.

At present substance misuse treatment in prisons is quite fragmentary, being divided between, among others, detox teams, standard healthcare, counselling and throughcare staff (CARAT workers) and purveyors of brief cognitive therapy (PASRO). In April this year the NHS takes over full responsibility. There is some hope that this strange mix will be rationalised, and perhaps merged into an in-reach addiction team that will respond to needs of inmates throughout their period of stay, while linking up with outside services. The Prison Health Unit is undertaking a review of needle exchange in prisons, so there is even a possibility that this might be introduced in place of the present reliance on disinfecting tablets, but don't hold your breath!

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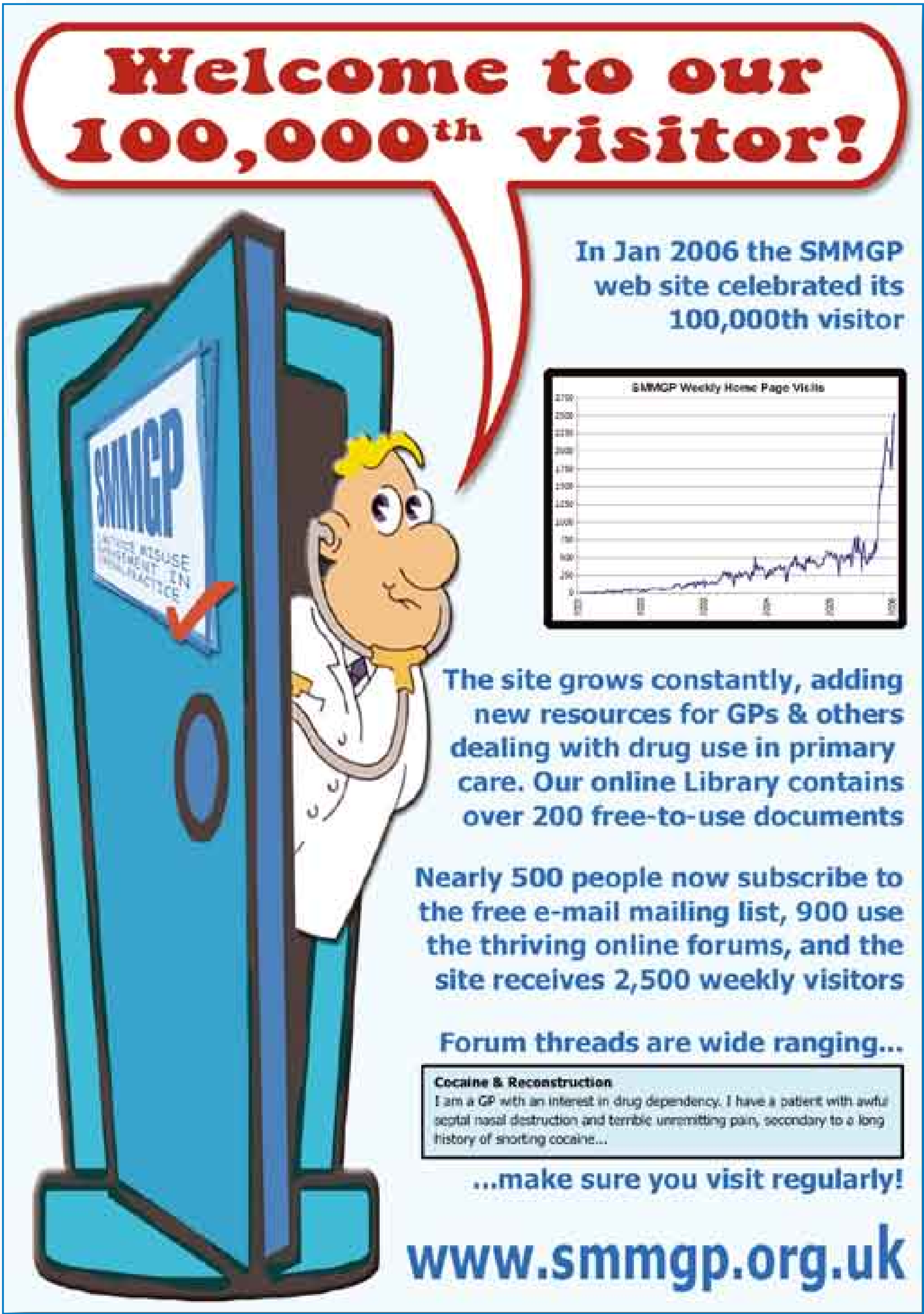
Welcome to our 100,000th visitor!
SMMGP
In Jan 2006 the SMMGP web site celebrated its 100,000th visitor
SMMGP Weekly Home Page Visits
The site grows constantly, adding new resources for GPs & others dealing with drug use in primary care. Our online Library contains over 200 free-to-use documents
Nearly 500 people now subscribe to the free e-mail mailing list, 900 use the thriving online forums, and the site receives 2,500 weekly visitors
Forum threads are wide ranging...
Cocaine & Reconstruction
I am a GP with an interest in drug dependency. I have a patient with awful septal nasal destruction and terrible unremitting pain, secondary to a long history of snorting cocaine...
...make sure you visit regularly!
www.smmgp.org.uk

Shared Care Monitoring Groups

SMMGP continues to look towards supporting the key strategic role of shared care coordination for effective development and maintenance of local treatment systems. Kate Halliday has drawn together SMMGP team experience into a briefing on *Shared Care Monitoring Groups.*

"A well functioning Shared Care Monitoring Group (SCMG) is central to the ongoing development of a high quality shared care scheme."

This article seeks to clarify the roles, responsibilities and membership of SCMG's.

The concept of the Shared Care Monitoring Group (SCMG) was first introduced in the Department of Health (DH) *Drug Misuse & Dependence - Guidelines on Clinical Management 1999.* In 2000 the DH issued terms of reference for SCMG's which is used as the basis of this paper. However SMMGP have included additional recommendations to reflect some of the changes in policy and practice that have occurred since the guidance was issued.

How should a SCMG work?

A SCMG is in essence a strategic group that influences and informs local decision making, whilst overseeing, monitoring and coordinating shared care. A SCMG should be clear about where it's decision making capacities lie. Many decisions will be able to be made by the SCMG, however, in some instances the group may act in an advisory role making recommendations that will then need to be agreed by other groups and agencies. For example the Local Medical Committee (LMC) should be consulted regarding GPs contracts, roles and responsibilities, and the DAT regarding commissioning issues. The decision making process will be different in each area so it is therefore important for the SCMG to clarify it's decision making remit with local multi agency agreement.

Case study A local training day involving GPs key workers and pharmacists was held as consultation for drawing up local guidelines for the new shared care scheme. The shared care coordinator then took the draft guidelines to the SCMG. The guidelines were ratified by the SCMG, on the condition that three further groups should be consulted. The PCT representative felt the Clinical Governance Lead should agree to the document, the DAT Commissioner felt that the Joint Commissioning Group should ratify the document, and the LMC representative felt it should be passed through the LMC. All other representatives felt that the consultation with their agencies was completed and agreed upon. Once full agreement was obtained, the documents were formally ratified by the SCMG.

What should a SCMG do?

The responsibilities of a SCMG will vary depending on the locality and the stage of development of the scheme, as priorities change from development, to maintenance and monitoring. The initial development of a scheme can be a busy and exciting time. However the SCMG is just as important in maintaining a scheme, when the focus can change to monitoring and improving quality, keeping up-to-date with policy support research and ongoing GP training and recruitment. Below is a list of suggested tasks for a SCMG. Those in italics were included in the existing DH guidance. Additional tasks that can be considered by a SCMG have been added to reflect the changes that have occurred since the guidance was issued. Each SCMG should clarify it's responsibilities locally with multi agency agreement. Additional tasks may be identified by local SCMG's that are not included in the list below:

- Develop partnership working between services in area to encourage a systems approach to treatment [SMMGP]
- Establish and review aims and objectives of scheme [SMMGP]
- *Introduce shared care into the locality* [DH]
- *Establish local guidelines for shared care* [DH]
- *Review existing services and contracts for local drug services where they relate to primary care, and make recommendations to commissioners for future service provision* [DH]
- *Monitoring key performance indicators* [DH]
- *Ensure mechanisms to stop leakage of diverted drugs, develop guidance on schemes to reduce leakage of prescription drugs, e.g. supervised consumption schemes* [DH]
- *Ensuring appropriate training and CPD are in place* [DH]
- Encourage the dissemination of new research findings, and the implementation of evidence based practice locally [SMMGP]
- Analysis of local needs assessments, and make recommendations regarding service delivery based upon the assessment [SMMGP]
- Initiate and analyse local prescribing audit, and develop a prescribing feedback system for practitioners [SMMGP]
- Ensure systems are in place for blood borne viruses immunization, testing and treatment within the shared care scheme [SMMGP]
- Establishing links with the PCT's clinical governance systems [SMMGP]
- Support the ongoing professional development of all professions involved in the scheme [SMMGP]
- Focus on the ongoing maintenance of local system once initial development phase is achieved [SMMGP]

Case study The SCMG agreed the following process for ensuring good quality clinical care. Prescribing Analysis and Cost (PACT) data is collated each quarter for every surgery involved in the scheme. The shared care coordinator analyses the figures and visits each surgery involved in the scheme every six months to give feed back on how the surgery is performing compared to local and average statistics, and the evidence base. In the meeting good performance, and areas for improvement are identified and an action plan is formulated for improving quality in the future.

Carrying forward the decisions of the SCMG

The SCMG will make a number of recommendations and suggested tasks. A shared care coordinator will often carry forward the majority of the tasks identified by the SCMG. Where this post does not exist, it is important that people have time within their existing posts to carry out the development work and coordination of the shared care scheme.

Maintaining a strategic focus

It is important to have an effective chair (for many areas this is a GP who participates in the scheme) who will keep to the agenda, identify named people to take forward action points, and check that the agreed action has taken place. It is important the group remains strategic, that it has clear terms of reference, with recorded action points to support clear outcomes. Principally, it needs to avoid becoming a talking shop on operational issues.

Case Study The SCMG met regularly but tended to discuss the same issues at each meeting (the need to recruit more GPs, and establish pharmacy guidelines) without any action taking place. The SCMG decided that although the attendees were committed to the scheme they did not have the time to carry forward the developments suggested at meetings. They put forward a proposal to the JCG for a shared care coordinator to be employed to carry out the developmental work and coordinate the scheme. The JCG agreed to the post, which was match funded by the DAT and the PCT.

Who should attend?

It is important for the SCMG to receive input from all stakeholders involved in the provision of primary care based treatment. The list below covers some of the people who ideally should be invited, or at least informed of the group's work (for example by sending minutes of meetings). Local differences in post, title and service provision will that mean that additional people may be added to this list. Service users and local practitioners from each relevant profession should be involved as they will provide essential feedback as to how the scheme is functioning. It is also important to involve local clinical leads to advise on quality and safety in clinical practice, and managerial and strategic leads to offer advice regarding local service provision.

- GPs*
- Community pharmacist*
- Local Pharmaceutical Committee (LPC) representative*
- Service Users
- Shared Care Co-ordinator
- PCT Commissioning Manager
- PCT Primary Care Manager/ Development lead
- Primary Care Clinical Lead
- DAT Manager/Commissioner
- Local Medical Committee (LMC) representative
- Lead NHS Trust clinical specialist/ consultant psychiatrist
- Statutory and non-statutory agency managers of shared care workers
- PCT Pharmaceutical Advisor
- PCT/DAAT Clinical Governance lead officer
- Director of Public Health/ representative

N.B consideration should be given to providing locum payments to self-employed members e.g. GPs, Pharmacists. *

How often should the SCMG meet?

The frequency of meetings will be decided locally, but it is common for a well-established group to meet at quarterly intervals. Many areas will chose to meet at more regular intervals because of local need or where a scheme is being set up and/ or going through a period of development.

Conclusion

For a SCMG to work effectively it is important that it clearly identifies it's strategic roles, responsibilities and has the right membership and effective chairing. Due to shared care's contribution in both quantity and quality of service provision in the delivery of drug treatment, SMMGP reiterates DH's guidance that SCMG's should be established in all areas, and that the group is given adequate time and resources to carry out it's responsibilities.

See article in Network Issue 12 , Shared Care Coordinator – How to Make Shared Care Schemes Work

Methadone and driving

Where the GP's responsibility lies in terms of patients on methadone who drive continues to concern many… for clarity look no further than the Methadone Guidance*

Applicants or drivers complying fully with a supervised oral methadone maintenance programme may be licensed, subject to favourable assessment and normally an annual medical review (DVLA, 2004). However, patients will be subject to revocation of their licence for a minimum 12 month period where it can be shown that there has been persistent use of, or dependency on, heroin; morphine; methadone and/or cocaine.* Once the 12 month period is completed the applicant will be assessed as to whether they can be licensed whilst on a methadone maintenance programme.

It is the patient's responsibility to inform the DVLA, and it is the doctor's responsibility to inform the patient of this. It is important to record that this advice has been given to the patient.

The DVLA and GMC also state that if doctors are aware that patients continue to drive in a dangerous way, then they should first press such patients more forcibly not to drive. If the patient continues to drive, doctors (at their discretion) should break confidentiality, inform DVLA and inform the patient that they are doing so. This is a very difficult area of practice. Doctors may not want to endanger the relationship with patients, but it would certainly be both tragic, as well as highly problematic, for any doctor, if patients hurt or kill people while driving in a manner already known to be unsafe.

More information is available on the DVLA website:www.dvla.gov.uk

***Excerpt from Guidance for the use of methadone for the treatment of opioid dependence in primary care. RCGP Substance Misuse Unit, RCGP Sex, Drugs and HIV Task Group, SMMGP, The Alliance, 1st Edition 2005 available at www.smmgp.org.uk**

[*Ed. This may mean that people need to discontinue driving when they first come into treatment]

Safer management of controlled drugs: early action

A much-needed DH update on legislation and developments in the *management of controlled drugs post Shipman.*

Introduction and Background

The Shipman Inquiry was set up on 31 January 2001 and was chaired by Lady Justice Janet Smith DBE as an independent public inquiry into the issues arising from the case of Harold Shipman. The Inquiry's Fourth Report was published on 14th July 2004. It focuses on the methods used by Harold Shipman to divert large quantities of potentially lethal controlled drugs and the reasons it was possible for him to do so for so long without detection.

The Shipman Inquiry concluded that there were serious shortcomings in current systems, and made a number of recommendations to strengthen the prescribing of controlled drugs and the ability to monitor their movement from prescriber to dispenser to patient (the "audit trail").

The government's response was published in December 2004 as *Safer management of controlled drugs.* The response accepts the case for some strengthening of current systems provided this can be done in a way that does not impede appropriate use of controlled drugs to meet patient needs. A comprehensive action programme to address the recommendations of the report is set out in the final chapter of the response.

Action so far

Some early changes in the legislation governing controlled drugs have now been implemented by amendments to the Misuse of Drugs Regulations. The principal changes are to allow:

- All details on prescriptions for controlled drugs except the signature to be computer generated;
- Computerisation of controlled drugs registers for drugs listed in Schedules 1 and 2;

Other measures will:

- Extend the list of controlled drugs which Extended Formulary Nurse Prescribers may prescribe for certain medical conditions (changes to the Prescription Only Medicines (Human Use) Order to bring these measures into effect will follow later this year);
- Amend the list of allowable drug paraphernalia to include ascorbic acid.

The changes came into force on 14 November 2005. You can access full details and a copy of Statutory Instrument 2005 No 2864 by clicking on the link www.circulars.homeoffice.gov.uk and is numbered HOC 48/2005.

Action planned for 1 April 2006

A number of further changes will be introduced, subject to Parliamentary approval where required, on 1 April 2006. In some cases the changes will be affected through professional guidance and in others through further amendment to the Misuse of Drugs Regulations. The key changes are:

- Introduction of special forms for any *private prescription* of schedule 2 & 3 controlled drugs dispensed by community pharmacists. Records of these prescriptions will be held on a central database so that they can be monitored by local PCTs;
- Some changes to the NHS prescription form to allow all prescriptions for controlled drugs to be correctly allocated to the individual prescriber and (subject to strict safeguards on confidentiality) to the individual patient;
- Modified arrangements for the dispensing of NHS prescriptions for schedule 2 & 3 controlled drugs, including a new requirement for patients or other people collecting medicines on their behalf to sign for them;
- Duration of any prescription for schedule 2, 3 & 4 controlled drugs to be restricted to 28 days;
- Introduction of 28 day maximum quantity on prescriptions for schedule 2, 3 & 4 controlled drugs;
- Introduction of requirement that all healthcare providers holding stocks of controlled drugs should have and comply with the terms of an agreed Standard Operating Procedure (SOP);
- Re-emphasis of professional guidance that doctors should prescribe controlled drugs for themselves or family members only in exceptional circumstances;
- Discretion for pharmacists (in closely defined circumstances) to correct technical errors in prescriptions where the prescriber's intention is clear, even if the prescriber cannot be contacted at the time.

Detailed guidance is being developed and will be available in early 2006.

Health Bill - Controlled drugs

The Health Bill, currently before Parliament, contains a series of clauses intended to strengthen the monitoring and inspection of controlled drugs in health and social care settings.

The key elements of the provisions are:

- Each healthcare organisation, NHS or private, will be required to nominate an officer of sufficient seniority – an "Accountable Officer" to ensure that the organisation has robust arrangements for the safe and effective management and use of controlled drugs. In NHS primary care, PCTs will exercise this responsibility on behalf of all the contractors with which it has contracted to provide services.
- A duty of collaboration will be placed on other local and national agencies, including professional regulatory bodies, police forces, the Healthcare Commission and the Commission for Social Care Inspection to share intelligence and agree joint action where there is evidence of misuse on controlled drugs issues.
- New powers of entry and inspection for authorised officers creates an unambiguous right of entry into all health and social care settings including GP premises.

- The Healthcare Commission will be required to assess the performance of all healthcare organisations, public and private, in relation to these responsibilities
- Better systems will support the vast majority of healthcare professionals who want to provide the best possible care for patients, but will also deter the small minority who may wish to abuse their professional position.

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http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/Prescriptions/PrescriptionsArticle/fs/en?CONTENT_ID=4123320&chk=5rfax4

Integrated care and partnership working – getting it right

A multidisciplinary team tackles the importance of integrated care and partnership working with some practical highlighting of joint working between the criminal justice, local specialist and GP services.

Michelle Williams, Community Crack Link Worker; Michael Lawson, Team Leader; Eyal Remon, DTTO Practitioner, Addaction Brent & Chris Ford GP Brent.

Introduction

The current government's public service reform agenda seeks to change the way in which government policies are delivered by encouraging local partnerships and innovation. New forms of resource allocation (e.g. Action Zones) and performance evaluation (e.g. Best Value) are emerging to allow such initiatives to develop, at the same time, providing assurances that public resources are being employed effectively. In the drugs field, we often need to work across agencies. Getting it right can improve treatment for drug users but how can we do this and what are the main obstacles?

What do we mean by integrated care and what is partnership working?

A variety of terms have been used to describe integrated working within the drugs field ranging from the Home Office definition of partnership work in 1992:

- *Partnership work:* the Home Office defined this as organisations with *"differing goals and traditions, linking to work together"* [1].
- To *shared* care in 1995: introduced by the Department of Health as the joint participation of specialists and primary care professionals, particularly GPs and pharmacists, in the planned delivery of care for patients with substance misuse problems, *"informed by an enhanced information exchange beyond routine discharge and referral letters"* [2].
- *Integrated* care in 2002: as an approach that *"seeks to combine and co-ordinate all the services required to meet the assessed needs of the individual"* [3].
- And the NTA in Models of Care in 2002 discussed *Joint working:* which involves drug services developing working relationships with other drug-related agencies or services to *"help establish the broadest range of seamless service delivery"* [4].

Partnership working case study

Michael aged 29 years came to treatment through the criminal justice system in Brent. He had a long history of heroin and cocaine problems and had never really engaged with treatment. He had been allocated a Drug Treatment Testing Order (DTTO) after appearing in court for credit card fraud. The DTTO support and group work ran from the Addaction Tier 2/3 services and a local GP was asked to help Michael with his mental health issues and for prescribing for his drug problems. The GP diagnosed depression with anxiety, commenced Cognitive Behavioural Therapy with the practice drug counsellor, prescribed antidepressants and titrated methadone to 120mg for his opiate dependence. He gained additional support from the compulsory DTTO group attendance together with keyworking around his crack problems. The regular good personal communication between the local GP, the counsellor, the DTTO worker and the keyworker at the Tier 2/3 service, placed Michael clearly at the centre of well coordinated, appropriate and effective care.

Therefore, despite its various guises, partnership working can ultimately be seen as a multi-agency collaboration at both strategic and operational levels which has patients and service users' needs as its unifying concern and delivers a coordinated range of services in a variety of settings in order to address those needs.

Who benefits from partnership working?

Working together with other organisations can bring considerable benefits to services, their users and the wider community. How so? By working in unison with other agencies, drug services will enjoy the potential to develop work that may not be possible for a single agency to undertake. For example, to offer crack specific harm reduction, needle exchange and advice on benefits to GPs or counselling services offering Cognitive Behavioural Therapy.

Joint working fully utilises available skills by using staff from different organisations, breaking down barriers to develop a better understanding of other services' skills and priorities, and enabling better communication between services.

There are also significant benefits to be reaped from engaging a community in genuine partnership. These benefits result in

1 *Home Office (1992) Partnership working in dealing with offenders in the community. London: Home Office.*

2 *Department of Health (1995) Reviewed shared care arrangements for drug misusers: executive letter: EL (95) 114. London: Department of Health.*

3 *Effective Interventions Unit (2002) Integrated care for drug users: principles and practice. Edinburgh: Scottish Executive.*

4 *National Treatment Agency (2002) Models of care for treatment of adult drug misusers: part 2. London: NTA.*

better-tailored services, and can assist in the development of the skills and capacity of the community as a whole. Services will be more able to target the community's needs through a comprehensive approach to the planning, commissioning and delivery of services, as well as promoting community involvement in the planning and delivery of services.

What factors can hinder partnership working?

Partnership working calls for effective management, governance, performance management, democratic control and accountability. However, a number of difficulties can become apparent when organisations work in partnership across the health, social care and criminal justice sectors. Inherent tensions include:

- Culture clashes, ideological differences and rivalry between organisations
- Difficulty maintaining continuity of care when there are multiple agencies involved
- Difficulties in establishing accountability arrangements
- Tensions between a health perspective and a criminal justice perspective (NTA, 2005[5]).

Conclusion

Partnership working and integrated care are essential if drug services and other agencies are to ensure that they are providing coordinated care for service users. Although difficulties may occur, it is imperative that we work together to overcome them.

All agencies involved need to clearly assign roles and responsibilities, developing protocols for information sharing, developing agreed performance targets and ensuring clear funding arrangements. Partnership is achieved when all of the individuals involved listen, share and respect each other's opinions, knowledge and mutual differences all with the patient clearly at the centre.

5 *National Treatment Agency (2005) Working in Partnership. London: NTA.*

Dr Fixit on joint working

Dear Dr Fixit

Roy aged 31 years, has just presented to me for help with his drug problem. He has been registered at the practice for a long time but has not sought help before for his drug problem. He tells me that he is using ½ gram of heroin by injection daily, but also crack and alcohol. He is drinking at least 75 units / week and this increases after he uses crack, which he does at least 3 times / week.

Because of his drug problem he has rowed with his parents and they have thrown him out of the house and he is now homeless and sleeping in various friends, also users, houses. He was also arrested a few weeks ago and the case comes to court in a couple of week's time. His solicitor has told him he will probably get a DTTO.

I am confident about substitute prescribing but I really need help with his crack and alcohol problems, as well as his housing and legal problems. What do you suggest? Where can I get this additional help?

Answer provided by
Dr Stephen Pick

Your question raises many important issues and is particularly relevant because the government and NTA now have multidisciplinary working high on their agendas. It can also be used to demonstrate how good integrated care pathways can work effectively. Good shared care is to do with coordination, cooperation and communication and all play a part if a vulnerable patient such as Roy is to benefit.

Roy is about to become involved in many agencies, all intending to help him. Hopefully he will be able to make the most of the help available and use it to motivate himself to make lasting changes in his life. However if the care is not good he may feel lost in the workings of the different agencies and become disillusioned. You say that you are confident in his substitute prescribing and you seem aware of the limitations of your knowledge and your role as his GP; this is an excellent basis for the establishment of good shared care. As his GP you will have a pivotal part in making sure all his difficulties are being dealt with but you will also need to let other agencies give the care that they are good at and you are unable to help with. In prescribing you should also be aware of the need to start safely and to titrate him at a rate which is quick enough to retain him with you but that is still safe. Getting his heroin use under control will enable you to build a good relationship in which he will have trust and confidence and this can be a mainstay for him when sorting his other issues out, so take care not to underestimate its importance. You should advise him about BBVs and all the issues around his injecting career.

There are many agencies that can become involved with Roy. I would hope that you have a Drug Service Unit that you can refer him to and that they are part of a shared care scheme. Some DSUs will do the initial titrating for you. You will find that you will be involved with a mixture of –

1) Partnership work between the criminal justice system and health care.

2) Joint working between the various drug related services, statutory and non statutory, so as to obtain a hopefully seamless care package.

3) Shared care which will link key workers, pharmacists yourself in primary care and secondary care and maybe a GPwSI if you have one.

4) Integrated care which will try to combine all of these. It is important that you work in the area that you feel confident with and allow those others to help you in their speciality.

So you may need to refer Roy to the specific alcohol service and ask the specialist DSU where the best place for him to get help with his crack use is. Referring him to these places does not mean you don't need to understand the problems. As his GP you will need to

know about them because there may be medical issues that occur. There is excellent guidance on Crack produced by the RCGP [1]. He may be involved with the Drug Interventions Program as he was arrested and they will have knowledge and connections with housing and street/homeless services, probation and social services. Getting to know your pharmacists is also very useful. I think that it would also help you if you made contact with the various services in your area and even visited them - time consuming but well worth the investment.

Reference:

1. RCGP Drug and Alcohol Misuse Training Programme, RCGP Sex, Drugs and HIV Task Group, SMMGP (2004), RCGP Guidance for Working with Cocaine and Crack Users in Primary Care

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Dr Fixit on coming off supervised consumption

Dear Dr Fixit

Sally, a 26 years old patient of mine is doing well on methadone maintenance. She lives with her partner, who also uses drugs and their two children 3 months and 3yrs. She came back into treatment during the last pregnancy having relapsed about a year before that. She tried reducing in the latter stages of pregnancy but struggled to not use heroin on top so she eventually stabilised 3 weeks post delivery on 120mg.

She has been on supervised consumption for this whole treatment episode of 5 months and has been stable with no other drugs in her urine for just over 2 months. Previously the urines had showed some cocaine and cannabis use. The baby is well, as is the older child and they are both well cared for. Unfortunately her partner has declined treatment.

She has requested to come off supervised consumption as it is getting increasingly difficult to manage the children and have her methadone supervised. She has also found previously that it helps her if she splits her dose.

What issues should I consider before responding to her request?

Answer provided by
Dr Judith Yates GP

You have done an excellent job, in engaging this young mother and helping her to stabilise on an optimal dose for her methadone maintenance, despite her previous poly drug use, the difficulties of the postnatal period and the obvious triggers which must be offered by a partner who is using and is not yet in treatment. After only two months avoidance of street drugs she will realise that she has a high risk of relapse and is likely to need your continued support.

The DH Clinical Guidelines 1999 [1], and indeed the Guidance for the use of Methadone in Primary Care" [2] suggest that methadone should be supervised for the first three months of a new episode of treatment. However both suggest that exceptions may be made and employment, child care or travel difficulties should be taken into consideration, so there is no doubt that you will be well within guidelines and would have peer group support if you decide to prescribe daily take home methadone for Sally at this stage. Indeed I would probably have considered this step earlier in the postnatal period.

However, before this is done, there are two main areas of danger which Sally would need to consider. The most important is the danger of accidental ingestion by young children where methadone is stored in the home. In Dublin it was found that 25% of households stored or measured methadone in unsuitable household containers, such as babies' bottles (I can see they would appear enticing, with their handy volume markings) [3]. In a different audit of 160 patients it was found that the vast majority of patients did not store their methadone in a locked or secure location [4].

The other area of uncertainty is the partner you suggest has declined treatment. If Sally has stored methadone at home, how will she avoid the pleas of her partner, on days of heroin famine?

I would suggest that if Sally feels it would be helpful, she should certainly now stop having supervised consumption, but remain on daily dispensing, which will be another step towards regaining her self esteem and control in her life, but first she should acquire a locked container or cupboard as she is intending to split her daily dose and has young children in the house.

[Ed. Some patients perceive a benefit from split dosing, but with the long half-life of methadone the pharmacological rationale is unclear]

Then concerted efforts should be made to understand and if possible to overcome her partner's reluctance to come into treatment, in order to reduce his effect as a trigger for Sally, and to enable the couple's available time, attention and money to be directed towards their children.

If he is to continue to be part of the family group, then his engagement in treatment would be vital for the continued well being of Sally and the children, so a bit of an effort to use the offer of take home doses for Sally as a bribe to encourage him in, might be thought worth a try. However I would offer this only as a suggestion to Sally, who would be the best judge of the likely therapeutic effectiveness of the move. She might be grateful for a lever to entice him in to see you, but her own excellent progress would justify a move to daily take home doses, and her successful treatment cannot become dependant on his.

References:

1. Department of Health: Drug Misuse and Dependence-Guidelines on Clinical Management. 1999 (available at www.SMMGP.org.uk)

2 Guidance for the use of Methadone for the treatment of opiod dependence in Primary Care (Ford C et al, RCGP 2005)

(available at www.SMMGP.org.uk)

3 Harkin K, Quinn C, Bradley F: Storing methadone in babies bottles puts young children at risk. BMJ 1999 318:329-330

4. Bloor R, McAuley R, Smalldridge N: Safe storage of methadone in the home- an audit of the effectiveness of safety information giving. Harm Reduction Journal 2005 2:9

The impact of 'Respect' on substance misusers

The Governments Respect agenda covering a raft of antisocial behaviour measures, whilst attempting to tackle offending can also impact support to some of the most vulnerable affected by drug and alcohol problems, as highlighted in London.

> ***"Rachel Hassan from WDP says it's important to remember users are part of the community while Victor Adebowale called the Respect Action Plan "a mistake.""***

Frontline workers are concerned at the impact of the Government's Respect Agenda on drug and alcohol users. Services working with substance misusers say the increasing use of antisocial behaviour initiatives does not solve drug and alcohol-related problems and impacts disproportionately on those who are most vulnerable. Turning Point chief executive Victor Adebowale called the Respect Action Plan launched earlier this year a "mistake" that "smacks of a quick fix solution to very serious and significant social problems".

A raft of antisocial behaviour measures affect drug and alcohol misusers including ASBOs, Acceptable Behaviour Contracts, Controlled Drinking Zones, on-the-spot fines, Dispersal Orders and crack house closures. Some specific concerns expressed by frontline workers interviewed by LDAN News were:

- Geographical ASBOs that attach a condition banning someone from a given area make it more difficult for clients to access key support services including drug dependency units where they pick up their methadone, local A+E departments and job centres.

- Clients with mental health problems can have difficulty understanding the implications of breaking ASBOs putting them at increased risk of being sent to prison. Evan Jones, head of community services at St Giles Trust in Camberwell, which has a large street drinking population, says he knows of at least two people with mental health issues who have been imprisoned for breaching alcohol-related ASBOs. They did not fully understand the implications of breaking the conditions, he says. "Those sent to prison tend to be those who are most vulnerable rather than the worst offenders".

- Controlled Drinking Zones (CDZs) that impose fines on people drinking within their boundaries hit chaotic users hardest. Unable to pay the initial fine, the tariff quickly spirals and can result in criminal proceedings. Local authorities across London have taken enthusiastically to setting up CDZs. The whole of Hillingdon for example has become a CDZ.

- There is insufficient publicity around Controlled Drinking Zones and Dispersal Orders. Often users only find out about them after they have been enforced.

- Given the priority attached to the antisocial behaviour agenda, services doing advocacy work on behalf of clients, are concerned it could endanger local authority administered funding to the project (though there is no indication this has happened). Services working with users are however managing to make a difference. They say liaison work has resulted in the use of more behaviour based rather than geographical ASBOs, and in reducing the duration of orders. They also say antisocial behaviour teams, including Camden's very busy one, are learning from earlier mistakes.

Rachel Hassan, from the Christopher Project, a community development initiative run by Westminster Drugs Project, says partnership working is proving effective in the borough but adds it is important to remember both sides of the debate when discussing antisocial behaviour. "The mentality 'let's get rid of these people from the community, let's move them on' forgets that these people are part of the community so we need to be talking about the support they need at the same time as dispersal zones". She adds that some of those most affected by drug misuse - users' families and carers – are usually absent from the debate because they are isolated and can lack support.

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A time of change – a big thanks to our GP leads

We would like to thank **Clare Gerada** who has recently handed over leadership of the RCGP Substance Misuse Unit, for her enormous energy, vision and resolve in helping lead the development of primary care in this field, and her contributions to both the SMU and SMMGP networks. We would also like to warmly welcome **Linda Harris** who is now standing in as the SMU Lead.

The RCGP Part 1 Certificate in the Management of Drug Misuse is to be managed by the RCGP SMU from April, now that the development phase undertaken by SMMGP is complete. We would like to thank the SMU for their close partnership working on the project and thank **Dr Jenny Keen** for her extraordinary contribution and dedication as Clinical Lead for the Part 1. Important thanks to **Chris Ford** for developing the Part 1 proposal and championing it's ongoing development. *(Part 1 Clinical Lead for RCGP Certificate in the Management of Drug Misuse sought – see bulletin board).*

A time of change no doubt, as we also need to thank **Nat Wright** for all his solid support as NTA GP Clinical Lead and welcome **Susi Harris** into post – the quality and scope of GP leadership available no doubt testament in some way to the effectiveness of the GP development networks.

prescribing news

Handwriting exemptions no longer required

As from the 14th November 2005 doctors no longer need to obtain a handwriting exemption from the Home office. Regulation 15 Misuse of Drugs Regulations 2001 has been amended to enable prescriptions to be written in any form, with only the signature necessarily being handwritten. The date may now be electronically produced.

Instalment dispensing – prescription wording to cover missed pick ups

As reported in the Pharmaceutical Journal - The Home Office has recently confirmed that the following wording can be used by those prescribing Controlled Drugs by way of instalment in accordance with the Misuse of Drugs Regulations 2001 ("Regulations"), as amended. This text is in addition to the usual Controlled Drug prescription requirements (words and figures, etc). The text reads: ***"Instalment prescriptions covering more than one day should be collected on the specified day; if this collection is missed the remainder of the instalment (ie, the instalment less the amount prescribed for the day(s) missed) may be supplied."***

Use of this wording will enable those supplying Controlled Drugs to issue the remainder of the instalment prescription where a person fails to collect the instalment on the specified day. If a prescription does not reflect such wording, the Regulations only permit the supply to be in accordance with the prescriber's instalment direction.

Want to attend a Part 1 RCGP Certificate in the Management of Drug Misuse?

The Part One consists of two e-learning modules and one face-to-face training day aimed at primary care health providers wishing to develop their skills and expertise from generalist through to Intermediate level.

Upcoming national events:

- York, 17th May 06
- London, 8th November 06

Contact tinkelaar@rcgp.org.uk 0207 173 6093

Upcoming local events that are willing to take other GPs on are

- South Gloucestershire 1st March 06
- Wandsworth, London 3rd March 06
- Hertfordshire 16th March 06
- Liverpool 31st March 06
- Rotherham 5th April 06
- Birmingham 24th May 06

Contact Mark Birtwistle,
mark.birtwistle@bstmht.nhs.uk 0161 772 3546

BULLETIN BOARD

Part One Clinical Lead for RCGP Certificate in the Management of Drug Misuse sought

The Substance Misuse Unit now seeks to recruit a Clinical Lead for the Part One of the Certificate Programme. This person will provide the clinical input to the programme, review and maintain the content and development, ensure that it remains fit for purpose. Dynamic, forward-thinking GPs with relevant experience with leadership, communication and liaison skills and an understanding of the wider political context of the substance misuse and governance fields. An annual consultancy fee of £10,000 is payable offered initially for one year and open to job share. Application requires a CV along with a personal statement, further enquiries to Jo Betterton, RCGP Project Manager, jbetterton@rcgp.org. **0207 173 6093. Closing Date: Tuesday 28th February. Interview date: Friday 24th March**

GPs, nurses and pharmacists can qualify for DANOS-based Drug & Alcohol Professional Accreditation.

The scheme is designed to provide a way for professionals to have their specialist skills and knowledge in the substance misuse field recognised throughout the field. Intended initially for non medical professionals to prove their competence some GPs and nurses may be interested in becoming accredited as a Drug & Alcohol Professional - particularly as **any GP or nurse with a qualification in substance misuse (such as the RCGP awards) would automatically qualify for accreditation** provided their competence were confirmed by a colleague. Visit the Federation of Drug and Alcohol Professionals (FDAP) site www.fdap.org.uk/certification/dap.html http://www.fdap.org.uk/certification/dap.html

11th National Conference: Management of Drug Users in Primary Care - Are we *Delivering Effective Care in General Practice?* Thursday 27th and Friday 28th April 2006, Manchester International Convention Centre.

The largest event in the UK for GPs, shared care workers, drug users, nurses and other primary care staff, specialists, commissioners and researchers interested in, and involved with, the management of drug users in primary care. The conference is committed to a progressive, multidisciplinary and practical look at the future of treatment, service design and delivery. Renowned for a wide mix of delegates and for encouraging and fostering animated, lively and honest debate. Also a great reputation for a highly social, friendly and fun event. Contact Healthcare Events on 0208 541 1399, email Katie@healthcare-events.co.uk, visit www.healthcare-events.co.uk or www.smmgp.org.uk for brochure.

The National Drug Treatment Conference, Thursday 9th and Friday 10th March at the Glasgow Radisson SAS Hotel. Organised by the Alliance and Exchange, this is now an essential part of the calendar for drug workers, activists, criminal justice workers, prison healthcare staff, clinicians, researchers, policy makers and commissioners. With a new perspective from being hosted in Scotland, the programme again brings together speakers from around the world to discuss key issues in drug treatment. Five major themes will be addressed by the conference: Marginalised groups, key clinical issues, prison healthcare commissioning, and pharmacy services. Contact www.exchangesupplies.org, info@exchangesupplies.org or **01305 262244**

SMMGP GP Website Discussion Forum Moderator - SMMGP are looking for discussion forum moderator for half a session a week ideally spread throughout the week. We would like to employ someone who is a forum user who has a good understanding of its ethos and who has the experience and knowledge to contribute useful advice and information to forum members. If you are interested please contact Jim Barnard for more information on **07717513711** or e-mail smmgp@freeuk.com.

Update on drug detoxification and methods to maintain abstinence

RCGP Certificate in the Management of Drug Misuse, Tuesday 13th June 2006, RCGP, Hyde Park London SW7 1PU

A day to update primary care professionals on drug detoxification and how to maintain abstinence:

- Are you up to date on the methods of drug detoxification and the best settings to undertake them?
- Do you want to know the role/legitimacy of providing abstinence options?
- What can we offer post detoxification
- What is the role of rehabilitation and what are the 12 steps all about?

Speakers include: Dr Gordon Morse – Clinical Director of Clouds and RCGP Regional Lead for South West Dr Chris Ford, GP and SMMGP Clinical Lead and Daphne Rumball consultant psychiatrist

Cost for the day: Past and current certificate applicants/graduates: £105

All other delegates: £135. ContactTerri Myers: 020 7173 6090/6093 or tmyers@rcgp.org.uk **RCGP, SMU Frazer House, 32-38 Leman Street, E1 8EW.**

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